223E (12/4/84)
Revised (09/11)

STATE OF UTAH
LABOR COMMISSION OF UTAH
DIVISION OF INDUSTRIAL ACCIDENTS

# RENEWAL APPLICATION FOR SELF-INSURANCE

PLEASE REVIEW THE RENEWAL APPLICATION, AS IT MUST BE COMPLETED IN FULL AND ALL REQUIRED ENCLOSURES MUST BE INCLUDED, OR IT MAY BE RETURNED WITH A **$150.00** RE-APPLICATION FEE

Self-Insured Name:_____ Federal ID #_____

1. **Address of principal office**_____
   E-Mail Address: _____ Internet Location:_____
2. **Person responsible for self-ins. program**: Name_____ Title_____
   Mailing Address:_____
   Phone # _____ Fax # _____ E-Mail Address:_____
3. **Contact if other than the above name:** Name_____ Title_____
   Mailing Address:_____
   Phone # _____ Fax # _____ E-Mail Address:_____
4. **Utah contact different from above names:** Name_____ Title:_____
   Utah Mailing Address:_____
   Phone #: _____ Fax #: _____ E-Mail Address:_____
5. **Person in charge of Safety Program:** Name_____ Title:_____
   Mailing Address:_____
   Phone #: _____ Fax #: _____ E-Mail Address:_____
6. **Send correspondence to:** Name_____ Title:_____
   Mailing Address:_____
   Phone #: _____ Fax #: _____ E-Mail Address:_____

7. **All open Utah workers' compensation claims, regardless of injury year.**
   a. Outstanding workers' compensation claims as of:_____ (date)
   b. Number of outstanding claims: _____
   c. Medical Reserve to be paid in the future: $_____
   d. Indemnity Reserve to be paid in the future: $_____
   e. Total Amount of Reserves: $_____
   f. Previously Reported Amount: $_____
   g. Total adjustment: $_____
   h. Where do you account for your Reserves:
      General Fund Account:____ Liability Fund Account: _____ Other: _____ -please attach explanation

8. a. **Information regarding the number of claims, amounts paid, burial benefits and dependent's benefits for the last three calendar years**.
   b. **Losses are to be reported for the calendar year <u>incurred</u> regardless of when payment was made.**

| | 20___ | 20___ | 20 |
|---|---|---|---|
| FATALITIES: | | | |
| # of Accidents | _____ | _____ | _____ |
| Medical Expenses | $ _____ | $ _____ | $ _____ |
| Burial Benefits | $ _____ | $ _____ | $ _____ |
| Dependents' Benefits | $ _____ | $ _____ | $ _____ |
| Total | $ _____ | $ _____ | $ _____ |
| * Reserves | $ _____ | $ _____ | $ _____ |
| Total Incurred Liability | $ _____ | $ _____ | $ _____ |
| Previously Reported | $ _____ | $ _____ | $ _____ |
| Total Adjustment | $ _____ | $ _____ | $ _____ |

| | | | |
|---|---|---|---|
| NONFATALS: | | | |
| # of Accidents | _____ | _____ | _____ |
| Medical Expenses | $ _____ | $ _____ | $ _____ |
| Temporary Total | $ _____ | $ _____ | $ _____ |
| Temporary Partial | $ _____ | $ _____ | $ _____ |
| Permanent Partial | $ _____ | $ _____ | $ _____ |
| Permanent Total | $ _____ | $ _____ | $ _____ |
| Total amount paid | $ _____ | $ _____ | $ _____ |
| * Reserves | $ _____ | $ _____ | $ _____ |
| Total Incurred Liability | $ _____ | $ _____ | $ _____ |

(Total amount paid on the calendar year's claims + the estimated reserves set aside to be paid on the outstanding claims for the same year)

| | | |
|---|---|---|
| Total Incurred Liability- | | |
| Previously Reported | $ _____ | $ _____ |
| Total Adjustment | $ _____ | $ _____ |

* Future estimated amount to be paid on claims incurred during the calendar year that the injury/illness occurred. For instance, you may have previously reported a $500,000 reserve for the injuries occurring during the calendar year of 2001. This year you now have set reserves at $400.000 for the 2001 losses. The adjusted amount would be $100,000.

9. **Claims handling Service (TPA):**

Name: _____ Contact Person: _____

Address: _____ Toll Free Phone #: _____

E-Mail Address: _____ Internet Location: _____

If the TPA and/or claims adjuster is not located in Utah, who is their **Designated Agent**? _____

_____ Phone #: _____

10. **Have there been any changes within the past year pertaining to the following areas? If so please provide information related to any statement with a yes response.**

a. Loss prevention Service Y ___ N ___

b. On site physician Y ___ N ___

c. Major changes to your employee handbook or procedures concerning workers' compensation Y ___ N ___

d. Managed health care provider, or designated health care provider Pertaining to workers' compensation Y ___ N ___

e. Number of Employees _____

f. Gross payroll exceeding 5 percent from previous year Y___ N ___

g. Has the company formed, acquired, changed, divested of, merged or started new business operations on their subsidiaries, companies or divisions since the last application, or from the original application ? Y ___ N ___

If yes, please attach an explanation along with the following information:
Name, Address, UI#, FEIN#, Effective date, Number of employees, Classification.

11. **The Company's NCCI Experience Modification as reported to the Utah Tax Commission for the previous calendar year**: _____.

12. **Has the company received any OSHA citations within the last year for the state of Utah?** Y ___ N ___ If so, how many _____ ? Attach an explanation of each citation.

13. **The renewal application must include:**

a. Audited Financial Statement (if the financial information cannot be obtained from Dunn & Bradstreet)

b. $650.00 renewal fee

c. Excess workers' compensation insurance certificate- if changed since previous year. Attach a copy of the insolvency endorsement also. **The excess carrier is still liable, if we do not receive a cancellation notice, even though they have an expiration date on the policy.**

**d.** **ALL** locations **(include any wholly owned subsidiaries) added** or **deleted** within the last 12 months. If additional locations please attach to the application.

## Locations Added

| | Name | Federal ID Number | Address | Date added |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

## Locations Deleted

| | Name | Federal ID Number | Address | Date deleted |
|---|---|---|---|---|
| 1. | | | | |
| 2. | | | | |
| 3. | | | | |
| 4. | | | | |
| 5. | | | | |
| 6. | | | | |
| 7. | | | | |
| 8. | | | | |
| 9. | | | | |
| 10. | | | | |

14. **The entire contents of this renewal application, including enclosures, are certified to be correct to the best of my knowledge, information and belief.**

_____
Name of Corporation or Public Entity

_____
Signature of Official of Corporation or Public Entity
with binding authority

15. **The entire contents of this renewal application, including enclosures are certified to be correct to the best of my knowledge, information and belief.**

By:_____
Signature

_____
Printed or typed name of person filing this form

Address:_____

_____

Phone # _____ Fax # _____

Subscribed and sworn to before me this
_____ day of _____ , 20____

By_____
(Notary Public)